TORRANCE PEDIATRIC DENTISTRY + ORTHODONTICS

3565 TORRANCE BLVD STE. B TORRANCE, CA 90503
P\310-792-6262 F\310-792-6203 hello@torrpdo.com

RICHARD SPAULDING, DDS
DIPLOMATE, AMERICAN BOARD OF PEDIATRIC DENTISTRY

SEPIDEH ARIARAD, DDS, MS
SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS

FAMILY HISTORY

CHILD'S FULL NAME: (PREFERRED NAME)	SEX ☐ MALE ☐ FEMALE	AGE DATE OF BIRTH

CHILD'S ADDRESS CITY ZIP CODE	BEST CONTACT PHONE NUMBER ( )

NAME OF PARENT #1 ☐ MOTHER ☐ FATHER ☐ GUARDIAN	CELL PHONE ( )	HOME PHONE ( )	WORK PHONE ( )

ADDRESS	SOCIAL SECURITY #	DATE OF BIRTH

EMAIL ADDRESS	EMPLOYER	OCCUPATION

NAME OF PARENT #2 ☐ MOTHER ☐ FATHER ☐ GUARDIAN	CELL PHONE ( )	HOME PHONE ( )	WORK PHONE ( )

ADDRESS	SOCIAL SECURITY #	DATE OF BIRTH

EMAIL ADDRESS	EMPLOYER	OCCUPATION

NAME & PHONE # OF CLOSE RELATIVE OR FRIEND ( )	HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT OF THIS OFFICE BEFORE? ☐ YES ☐ NO IF YES, NAME:

NAME OF CHILD'S SIBLINGS AND THEIR AGES

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

IS YOUR CHILD COVERED BY A DENTAL PLAN? ☐ YES ☐ NO	IF SO, UNDER WHOSE PLAN IS THE CHILD COVERED? ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ DUAL COVERAGE

NAME OF PARENT INSURED	NAME OF INSURANCE CARRIER	INSURANCE PHONE # ( )	GROUP OR POLICY #
NAME OF PARENT INSURED	NAME OF INSURANCE CARRIER	INSURANCE PHONE # ( )	GROUP OR POLICY #

IS YOUR CHILD COVERED BY A MEDICAL PLAN? ☐ YES ☐ NO	IF SO, UNDER WHOSE PLAN IS THE CHILD COVERED? ☐ FATHER ☐ MOTHER ☐ GUARDIAN ☐ DUAL COVERAGE

NAME OF PARENT INSURED	NAME OF INSURANCE CARRIER	INSURANCE PHONE # ( )
NAME OF PARENT INSURED	NAME OF INSURANCE CARRIER	INSURANCE PHONE # ( )

I hereby authorize Dr. Richard A Spaulding, DDS and/or Dr. Sepideh Ariarad, DDS, MS to perform any and all treatment for my above named child and consent to such methods, drugs, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

PLEASE NOTE: Payment is expected for service rendered at the time of each visit. Financial arrangements may be made following the diagnosis. A 1 ½ percent monthly finance charge is added to all amounts after 90 days. This represents an annual percentage charge of 18 percent.

SIGNATURE OF PARENT OR LEGAL GUARDIAN	RELATIONSHIP TO PATIENT	DATE

These Questions Are of Great Value in Aiding Us To A Better Understanding Of Your Child

TODAY'S DATE

CHILD'S FULL NAME: (PREFERRED NAME) | SEX ☐ MALE ☐ FEMALE | AGE | DATE OF BIRTH

SCHOOL | GRADE | WHOM CAN WE THANK FOR REFERRING YOU?

REASON FOR THIS VISIT

MEDICAL AND DENTAL HISTORY

CHILD'S PEDIATRICIAN | CITY | PHONE ( ) | DATE LAST SAW PEDIATRICIAN

1. Was your child born of a normal 9 mos. term pregnancy? ☐ YES ☐ NO
   If premature, how many months? _____Months
2. Is your child presently under the care of a physician? ☐ YES ☐ NO
   If yes, why? _____
3. Has your child ever been hospitalized? ☐ YES ☐ NO
   If yes, why? _____
4. Is your child taking any medications now? ☐ YES ☐ NO
   If yes, why? _____
5. Is your child handicapped in any way? ☐ YES ☐ NO
   If yes, how? _____
6. Is your child allergic to any medications, foods or latex? ☐ YES ☐ NO
   If yes, what? _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS?

	Y	N		Y	N		Y	N
1. Heart Trouble or Murmur	☐	☐	9. Hepatitis	☐	☐	17. Speech/Learning Disabilities	☐	☐
2. Rheumatic Fever	☐	☐	10. Bleeding Problems	☐	☐	18. Eye Problems	☐	☐
3. Brain Injury	☐	☐	11. Anemia	☐	☐	19. Skin Disorders	☐	☐
4. Diabetes	☐	☐	12. Blood Transfusion	☐	☐	20. Emotional Disturbances	☐	☐
5. Asthma	☐	☐	13. Bladder/Kidney Disorders	☐	☐	21. HIV Positive/AIDS	☐	☐
6. Epilepsy/Seizures	☐	☐	14. Ear Infections	☐	☐	22. Adolescent Women:		
7. Cleft Palate/Lip	☐	☐	15. Cerebral Palsey	☐	☐	a. Pregnant Now or Might be	☐	☐
8. Cancer	☐	☐	16. Mental Retardation	☐	☐	b. Taking Birth Control Pills	☐	☐
						b. Ever Taken Diet/Weight Loss Medications	☐	☐

23. Other Conditions Y ☐ N ☐ If yes, please explain: _____

CHILD'S FIRST DENTAL VISIT? ☐ YES ☐ NO | PREVIOUS DENTIST | CITY | DATE OF LAST VISIT

ANY INJURIES TO TEETH OR JAWS? (Falls, Blows, Chips, etc) ☐ YES ☐ NO | EXPLAIN NATURE OF INJURY AND DATE

HISTORY OF: ☐ Thumb/Finger Sucking ☐ Pacifier ☐ Lip Sucking ☐ Tongue Thrusting ☐ Teeth Grinding

IS YOUR CHILD STILL USING A BOTTLE? ☐ YES ☐ NO

ANY UNFAVORABLE REACTIONS TO PREVIOUS MEDICAL OR DENTAL CARE? ☐ YES ☐ NO | IF YES, EXPLAIN

HOW DO YOU THINK YOUR CHILD WILL ACT TOWARD THE DENTIST? | NAME OF FAMILY DENTIST | CITY

HOW OFTEN DOES YOUR CHILD BRUSH? | IS BRUSHING ASSISTED BY AN ADULT? ☐ YES ☐ NO | DO THE GUMS BLEED WHEN THE TEETH ARE BRUSHED? ☐ YES ☐ NO

IS DENTAL FLOSS USED? ☐ YES ☐ NO | DOES YOUR CHILD RECEIVE? ☐ FLUORIDE TOOTHPASTE ☐ FLUORIDATED WATER ☐ FLUORIDE IN VITAMINS ☐ NONE

ANYTHING ELSE YOU WISH TO BRING TO THE DOCTOR'S ATTENTION? _____

Reviewed by Dr. _____ Date _____